SWEDBERG EYE CARE
OPHTHALMOLOGY CLINIC
21827 76th Avenue West, Suite 102, Edmonds, WA 98026 **(425) 778-2500** fax (425) 778-5600

PATIENT INFORMATION FORM

Please fill out the information to the best of your ability. Complete and accurate information allows us to give you the best service possible.

PERSONAL INFORMATION

Name: First: _____ MI: _____ Last: _____

Date of Birth: _____ Social Security # _____ (Must include for Tricare) Gender: _____

Ethnicity / Language: _____

Do you need an interpreter (circle)? YES NO

CONTACT INFORMATION

Mailing address: _____

City: _____ State:____ Zip: _____

Primary Phone #:_____ Cell Phone #: _____

May we leave a message that contains medical information on your cell phone (circle)? YES NO

Email address: _____

Employer: _____ Phone: _____

Marital Status: _____Spouse's Name: _____

Emergency Contact: _____ Phone: _____

Primary Care Physician: _____ Facility: _____

Referring Physician: _____ City: _____

Pharmacy _____ City: _____ Phone:_____

Person Responsible for Payment: _____

DOB: _____ Social Security #: _____ Relationship: _____

Phone: _____ Address: _____

City: _____ State: _____ Zip: _____

INSURANCE INFORMATION

Primary Insurance: _____ ID / Member Number: _____

Group #: _____ Policy Holder: _____ DOB: _____

Secondary Insurance: : _____ ID / Member Number: _____

Group #: _____ Policy Holder: _____ DOB: _____

ASSIGNMENT AND RELEASE: I hereby authorize my insurance benefits be paid directly to Dr. Steven H. Swedberg, MD PS as well as release of any information by provider or insurance company required for this account.
PAYMENT: I agree that I am responsible for providing up to date health insurance information and am financially responsible for the balance remaining after insurance adjudication. I agree to make payment arrangements for any unpaid balances due after 30 days after the billing statement.

SIGNED: _____ DATE: _____

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NOTICE OF PRIVACY PRACTICES-ACKNOWLEDGMENT

We keep a record of the health care services we provide you. You may ask for your records at any time for a fee of $20.00. You may also ask to correct that record. We will not disclose your medical records to others unless you sign a release of medical records request form or if the law authorizes us to do so.

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed and how you may access your information.

By signing below I acknowledge receipt of the **Notice of Privacy Practices**, and have been informed of our office **Financial Policy** and **Refraction Fee** on the previous page.

_____ _____
Patient or Legal Guardian Date

_____ _____
Printed Name Relationship

_____ _____
Printed name of person we may disclose medical information to in the case of an emergency. Relationship

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FINANCIAL POLICY

We are committed to providing you with the best possible eye care. If you have medical insurance, we will bill your insurance carrier as a service to you. Swedberg Eye Care's payment policy is as follows:

Payment for services are due at that time the services are rendered unless payment arrangements have been arranged in advance. Understanding your health care insurance plan may be difficult but we are here to help.

1. Your insurance is a contract between you, your employer and the insurance company. **You need to make every effort to understand what your insurance will pay for and what they will expect you to pay for.**

2. **Referrals from your Primary Care Physician and Authorization from your Insurance Plan, are often required under your policy.** It is your responsibility to check with your insurance to see if any of these are required and to ask your Primary Care Physician for a referral to see another physician.

3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select services they will not cover. For example, **some insurance policies will not cover routine eye exams and refractions, thereby making you completely responsible for the charges**. A **Refraction** is the process of determining the eye's refractive error for an eyeglass prescription. This exam is not a covered service by **Medicare**, **Secure Horizons** or most other insurances. The **refraction fee is $70.00** and due at the time of service.

4. As the patient, you are responsible for payment for services received. We will do our best to bill your insurance first. All balances are your responsibility. We accept cash, Visa, Master Card, Care Credit and checks payable to Dr. Steven H Swedberg, MD, PS. Convenient payment plans may be arranged.

We must emphasize that, as medical care providers, our relationship is with you, not your insurance company. We will gladly discuss your proposed treatment and answer any questions related to your insurance.

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account. We are happy to make your visits to us affordable for you, and will work with you to establish a plan that can work for everyone.

If you have any questions about the above information or any uncertainty regarding insurance coverage, please do not hesitate to ask us. We are here to help.

There will be a fee of $30 for all NSF checks. Past due accounts over 60 days will be charged a minimum of $5.00 per month. Past due accounts over 90 days may face collection proceedings.

Name: _____ Date: _____

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MEDICARE / MEDIGAP AUTHROIZATION

Patient's Name_____ Date of Birth _____

Medicare Member ID #_____ Account # _____

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. Steven H. Swedberg, MD for any service furnished to me by that physician. I authorize release to the Centers for Medicare and Medicaid Services and its agents any medical information about me needed to determine the payments for related services.

_____ _____
Signature of Beneficiary, Guardian or Personal Representative Date

_____ _____
Printed Name of Guardian or Personal Representative Date

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REFRACTION ACKNOWLEDGMENT

You will NOT receive a Refraction unless the physician determines that it is necessary

By signing below you acknowledge that we have informed you of the following:

- **You may refuse the refraction.**
- Refractions are not generally paid by insurance.
- Without a refraction, a prescription for glasses will not be available from your visit.
- Our office fee for a refraction is $70.00 we will mail you a bill once your insurance has processed the visit.
- This fee in addition to any insurance copayment at the time of service.

A **refraction** is the process of determining the eye's refractive error for an eyeglass prescription and as a diagnostic test to determine the medical necessity for surgery. It is an essential part of an eye examination, but is **NOT** always a covered service by the majority of insurance companies including Medicare and AARP.

ACKNOWLEDGMENT

I have read the above information and understand that the **refraction** is a **non-covered service** by **Medicare** and/or my insurance. I except full financial responsibility for the cost of this service should I receive one. I understand that the insurance copayment is separate from and not included in the refraction fee.

_____ _____

Patient signature (Parent for minor) Date

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HEALTH HISTORY

Patient Name: _____ Date: _____

Medical History (check all that apply)

___ High Blood Pressure	___Hepatitis	___Glaucoma	___Retinal Detachment
___Heart Problems	___Thyroid Disease	___Keratoconus	___Strabismus
___Diabetes	___HIV Positive	___Cataract	___Eye Injury
___Arthritis	___Cancer	___Macular Degeneration	___Eye Surgery

Medications: _____	Medication Allergies:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please list all Eye Surgeries and any Recent /Past Major Surgeries:

_____

_____

Review of Systems:	YES	NO	If YES, please explain
Do you have any of the following problems:	___	___	_____
Chronic fever, unexpected weight loss/gain, fatigue	___	___	_____
Ear/nose/throat problems (e.g. hearing loss, sinus problems)	___	___	_____
Heart Problems (e.g. chest pain, irregular heart beat)	___	___	_____
High Blood Pressure	___	___	_____
Respiratory problems (e.g. shortness of breath, wheezing)	___	___	_____
Hay Fever	___	___	_____
Gastrointestinal problems (e.g. abdominal pain, diarrhea)	___	___	_____
Urinary problems (e.g. pain or discomfort, blood in urine)	___	___	_____
Skin problems (e.g. rashes, excessive dryness)	___	___	_____
Musculoskeletal problems (e.g. muscle aches, joint pain)	___	___	_____
Neurologic problems (e.g. numbness, weakness, headaches)	___	___	_____
Endocrine problems (e.g. diabetes, thyroid)	___	___	_____
Psychiatric problems (e.g. depression, anxiety)	___	___	_____

Family History:

___ Blindness	___Crossed/Lazy Eye	___Glaucoma
___Retinal Detachment	___ Cataract	___Macular Degeneration

Social History:

Tobacco Use:	___Former	___Currently	___Never
Alcohol History:	___Occasionally	___Daily	___Never

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